

**Kotak Mahindra General Insurance Company Ltd.**

Registered Office: 27 BKC, C 27, G Block, Bandra Kurla Complex, Bandra East, Mumbai – 400051. Maharashtra, India.

20-21/V1

## Kotak Health Care - Policy Wordings

### PART II OF THE POLICY

This is a contract of insurance between You and Us which is subject to the receipt of the premium in full and the terms, conditions and exclusions of this Policy. This Policy has been issued on the basis of the Disclosure to Information Norm, including the information provided by You in respect of the Insured Persons in the Proposal Form. Please inform Us immediately of any change in the address, state of health or any other changes affecting You or any Insured Person.

### 1. DEFINITIONS

For the purposes of this Policy, the terms specified below shall have the meaning set forth wherever appearing/specified in this Policy or related Extensions/Endorsements:

Where the context so requires, references to the singular shall also include references to the plural and references to any gender shall include references to all genders. Further any references to statutory enactment include subsequent changes to the same.

Accident	means sudden, unforeseen and involuntary event caused by external, visible and violent means.
Admission	means the Insured Person's admission to a Hospital as an inpatient for the purpose of medical treatment of an Injury and/or Illness.
Alternative Treatments (AYUSH)	refers to the medical and/ or hospitalization treatments given under Ayurveda, Yoga and Naturopathy, Unani, Sidha and Homeopathy systems
AYUSH Hospital	is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH Medical Practitioner(s) comprising of any of the following: <ul style="list-style-type: none"> <li>a. Central or State Government AYUSH Hospital or</li> <li>b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy; or</li> <li>c. AYUSH Hospital, standalone or co-located with in-patient healthcare facility of any recognized system of medicine, registered with the local authorities, wherever applicable, and is under the supervision of a qualified registered AYUSH Medical Practitioner and must comply with all the following criterion: <ul style="list-style-type: none"> <li>i. Having at least 5 in-patient beds;</li> <li>ii. Having qualified AYUSH Medical Practitioner in charge round the clock;</li> <li>iii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;</li> <li>iv. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative</li> </ul> </li> </ul>
AYUSH Day Care Centre	means and includes Community Health Centre (CHC), Primary Health Centre (PHC), Dispensary, Clinic, Polyclinic or any such health centre which is registered with the local authorities, wherever applicable and having facilities for carrying out treatment procedures and medical or surgical/para-surgical interventions or both under the supervision of registered AYUSH Medical Practitioner (s) on day care basis without in-patient services and must comply with all the following criterion: <ul style="list-style-type: none"> <li>i. Having qualified registered AYUSH Medical Practitioner(s) in charge;</li> <li>ii. Having dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out;</li> <li>iii. Maintaining daily records of the patients and making them accessible to the insurance company's authorized representative.</li> </ul>
Ambulance	means a road vehicle operated by a licensed/authorised service provider and equipped for the transport and paramedical treatment of the person requiring medical attention.
Base Annual Sum Insured	means the amount specified in the Policy Schedule which is Our maximum, total and cumulative liability for any and all Claims during the Policy Year in respect of all Insured Persons. If the Policy Period is more than one year, then the Base Annual Sum Insured will apply afresh to each Policy Year in the Policy Period, but any portion of the Base Annual Sum Insured which remains un-utilised in any Policy Year shall not be carried forward to any subsequent Policy Year in the Policy Period.
Any one illness	means continuous period of illness and includes relapse within 45 days from the date of last consultation with the Hospital / Nursing Home where treatment was taken
Associated Medical Expenses	means Room Rent, nursing charges, operation theatre charges, fees of Medical Practitioners (including surgeons, anesthetists and specialists)
Cashless Facility	means a facility extended by the insurer to the insured where the payments, of the costs of treatment undergone by the insured in accordance with the policy terms and conditions, are directly made to the network provider by the insurer to the extent pre authorization is approved.
Claim	means a demand made by You for payment of any benefit under the Policy in respect of an Insured Person.
Condition Precedent	means a policy term or condition upon which the Insurer's liability under the policy is conditional upon.
Congenital Anomaly	means a condition which is present since birth, and which is abnormal with reference to form, structure or position. <ul style="list-style-type: none"> <li>i. Internal Congenital Anomaly -Congenital anomaly which is not in the visible and accessible parts of the body</li> </ul>

	ii. External Congenital Anomaly- Congenital anomaly which is in the visible and accessible parts of the body.
Cumulative Bonus	means any increase or addition in the Sum Insured granted by the insurer without an associated increase in premium.
Day care center	means any institution established for day care treatment of illness and / or injuries or a medical set -up with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under:- <ul style="list-style-type: none"> <li>- has qualified nursing staff under its employment;</li> <li>- has qualified medical practitioner (s) in charge;</li> <li>- has a fully equipped operation theatre of its own where surgical procedures are carried out</li> <li>- maintains daily records of patients and will make these accessible to the Insurance company's authorized personnel.</li> </ul>
Day Care Treatment	refers to medical treatment, and/or Surgical Procedure which is: <ol style="list-style-type: none"> <li>i. undertaken under General or Local Anesthesia in a Hospital/Day care centre in less than 24 hrs because of technological advancement, and</li> <li>ii. which would have otherwise required hospitalization of more than 24 hours.</li> </ol> Treatment normally taken on an out-patient basis is not included in the scope of this definition.
Dental treatment	means a treatment related to teeth or structures supporting teeth including examinations, fillings (where appropriate), crowns, extractions and surgery
Dependants	means Your legally married spouse, Your natural or adopted dependent children and Your dependent parents.
Disclosure to information norm	The Policy shall be void and all premium paid thereon shall be forfeited to the Company, in the event of misrepresentation, mis-description or non-disclosure of any material fact.
Domiciliary Hospitalisation	means medical treatment for an illness/disease/injury which in the normal course would require care and treatment at a hospital but is actually taken while confined at home under any of the following circumstances: <ol style="list-style-type: none"> <li>i. The condition of the patient is such that he/she is not in a condition to be removed to a hospital, or</li> <li>ii. The patient takes treatment at home on account of non-availability of room in a hospital.</li> </ol>
Emergency	shall mean a serious medical condition or symptom resulting from Injury or sickness which arises suddenly and unexpectedly, and requires immediate care and treatment by a Medical Practitioner, generally received within 24 hours of onset to avoid jeopardy to life or serious long term impairment of the Insured Person's health, until stabilisation at which time this medical condition or symptom is not considered an emergency anymore.
Emergency Care	means management for an illness or injury which results in symptoms which occur suddenly and unexpectedly, and requires immediate care by a medical practitioner to prevent death or serious long term impairment to the insured person's health.
Family Floater	means a Policy described as such in the Policy Schedule where under You and Your dependents named in the Schedule are insured under this Policy as at the Policy Period Start Date. The Base Annual Sum Insured for a Family Floater means the sum shown in the Schedule which represents Our maximum liability for any and all claims made by You and/or all of Your dependents during each Policy Period.
Grace Period	means the specified period of time immediately following the premium due date during which a payment can be made to renew or continue a Policy in force without loss of continuity benefits such as waiting periods and coverage of Pre-existing Diseases. Coverage is not available for the period for which no premium is received.
Hospital	means any institution established for in- patient care and day care treatment of illness and / or injuries and which has been registered as a hospital with the local authorities under the Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said Act OR complies with all minimum criteria as under: <ol style="list-style-type: none"> <li>i. has qualified nursing staff under its employment round the clock;</li> <li>ii. has at least 10 inpatient beds, in those towns having a population of less than 10,00,000 and 15 inpatient beds in all other places;</li> <li>iii. has qualified medical practitioner (s) in charge round the clock;</li> <li>iv. has a fully equipped operation theatre of its own where surgical procedures are carried out</li> <li>v. maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.</li> </ol>
Hospitalisation	means admission in a Hospital for a minimum period of 24 consecutive 'In- patient Care' hours except for specified procedures/treatments, where such admission could be for a period of less than 24 consecutive hours
In-patient care	means treatment for which the insured person has to stay in a Hospital for more than 24 hours for a covered event.
Illness	means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment. <ol style="list-style-type: none"> <li>i. <b>Acute condition</b> - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the</li> </ol>

	<p>disease/illness/injury which leads to full recovery.</p> <p>ii. <b>Chronic condition</b> - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:-</p> <ol style="list-style-type: none"> <li>a. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and / or tests</li> <li>b. it needs ongoing or long-term control or relief of symptoms</li> <li>c. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it</li> <li>d. it continues indefinitely</li> <li>e. it recurs or is likely to recur.</li> </ol>
Injury	means accidental physical bodily harm excluding illness or disease solely and directly caused by external, violent, visible and evident means which is verified and certified by a Medical Practitioner.
Insured Person(s)	means the individual(s) named in the Policy Schedule who are covered under this Policy.
Intensive Care Unit	means an identified section, ward or wing of a Hospital which is under the constant supervision of a dedicated medical practitioner(s), and which is specially equipped for the continuous monitoring and treatment of patients who are in a critical condition, or require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the ordinary and other wards.
Maternity Expenses	means - <ol style="list-style-type: none"> <li>i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during Hospitalization);</li> <li>ii. Expenses towards lawful medical termination of pregnancy during the policy period.</li> </ol>
Medical Advice	means any consultation or advice from a Medical Practitioner including the issue of any prescription or follow-up prescription.
Medical Expenses	means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.
Medically Necessary treatment	means any treatment, tests, medication, or stay in hospital or part of a stay in hospital which <ol style="list-style-type: none"> <li>i. is required for the medical management of the illness or injury suffered by the insured;</li> <li>ii. must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;</li> <li>iii. must have been prescribed by a medical practitioner;</li> <li>iv. must conform to the professional standards widely accepted in international medical practice or by the medical community in India.</li> </ol>
Medical Practitioner	means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.  The term Medical Practitioner would include physician, specialist, anaesthetist and surgeon but would exclude You and Your Immediate Family. "Immediate Family would comprise of Your spouse, dependent children, brother(s), sister(s) and dependent parent(s).
Migration	means, the right accorded to health insurance policyholders (including all members under family cover and members of group health insurance policy), to transfer the credit gained for pre-existing conditions and time bound exclusions, with the same insurer
Network Provider	means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.
Newborn Baby	means baby born during the Policy Period and is aged upto 90 days
Non- Network Provider	means any Hospital, day care centre or other provider that is not part of the network.
Notification of Claim	means the process of intimating a claim to the insurer or TPA through any of the recognized modes of communication
OPD treatment	means one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.
Plan	means the plan stated in the Policy Schedule which is applicable to all Insured Persons and specifies the amounts of benefits payable.
Policy	means these Policy wordings, the Policy Schedule and any applicable endorsements or extensions attaching to or forming part thereof. The Policy contains details of the extent of cover available to You, what is excluded from the cover and the terms & conditions on which the Policy is issued to You.
Policy Period	means the period commencing from the Policy Period Start Date, Time and ending at the Policy Period End Date, Time of the Policy and as specifically appearing in the Policy Schedule.
Policy Schedule	means the schedule attached to and forming Part I of this Policy, mentioning the details of the Insured Persons, the Base Annual Sum Insured, the period and the limits to which benefits under the Policy are subject to, including any annexures and/or endorsements, made to or on it from time to time, and if more than one, then the latest in time.
Policy Year	means a period of twelve months beginning from the Policy Period Start Date and ending on the last day

	of such twelve-month period. For the purpose of subsequent years, "Policy Year" shall mean a period of twelve months beginning from the end of the previous Policy Year and lapsing on the last day of such twelve-month period, till the Policy Period End Date, as specified in the Policy Schedule.
Portability	means the right accorded to an individual health insurance policyholder (including all members under family cover), to transfer the credit gained for pre-existing conditions and time bound exclusions, from one insurer to another insurer
Pre-existing Disease	means any condition, ailment, injury or disease a) That is/are diagnosed by a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement Or b) For which medical advice or treatment was recommended by, or received from, a physician within 48 months prior to the effective date of the policy issued by the insurer or its reinstatement.
Pre-Hospitalisation Medical Expenses	means medical expenses incurred during pre-defined number of days preceding the hospitalisation of the Insured Person, provided that: i. Such Medical Expenses are incurred for the same condition for which the Insured Person's Hospitalisation was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company
Post-Hospitalisation Medical Expenses	means medical expenses incurred during pre-defined number of days immediately after the Insured Person is discharged from the hospital, provided that: i. Such Medical Expenses are for the same condition for which the Insured Person's Hospitalisation was required, and ii. The In-patient Hospitalization claim for such Hospitalization is admissible by the Insurance Company.
Qualified Nurse	means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.
Reasonable & Customary Charges	means the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness/injury involved.
Renewal	means the terms on which the contract of insurance can be renewed on mutual consent with a provision of grace period for treating the renewal continuous for the purpose of gaining credit for pre-existing diseases, time-bound exclusions and for all waiting periods.
Room Rent	means the amount charged by a hospital towards Room and Boarding expenses and shall include associated medical expenses.
Surgery or Surgical Procedure	means manual and/or operative procedure (s) required for treatment of an illness or injury, correction of deformities and defects, diagnosis and cure of diseases, relief from suffering or prolongation of life, performed in a hospital or day care centre by a Medical Practitioner.
Third Party Administrator (TPA)	means any person who is registered under the IRDAI (Third Party Administrators – Health Services) Regulations, 2016 notified by the Authority and is engaged, for a fee or remuneration by an insurance company for the purposes of providing health services as defined in those Regulations
Unproven/Experimental Treatment	means the treatment including drug experimental therapy which is not based on established medical practice in India, is treatment experimental or unproven.
You/Your/Policyholder	means the Policy holder named in the Policy Schedule.
We/ Our/Us	means the Kotak Mahindra General Insurance Company Limited.

## 2. WHAT WE WILL PAY (SCOPE OF COVER OF BENEFITS AVAILABLE UNDER THE POLICY)

The Benefits available under this Policy are described below. Benefits will be payable subject to the terms, conditions and exclusions of this Policy and the availability of Base Annual Sum Insured and Cumulative Bonus and subject always to any sub-limits specified in respect of that Benefit and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule.

Our total liability under this Policy for payment of any and all Claims in the aggregate during each Policy Year of the Policy Period shall not exceed the sum of the Base Annual Sum Insured and the Cumulative Bonus (if any):

### 2.1 In-patient Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Hospitalisation during the Policy Period following an Illness or Injury for a minimum and continuous period of 24 hours that occurs during the Policy Period provided that:

- The Hospitalisation is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
- The Medical Expenses incurred are Reasonable and Customary;

### 2.2 Day Care Treatment

We will indemnify the Medical Expenses incurred on the Insured Person's Day Care Treatment during the Policy Period following an Illness or Injury that occurs during the Policy Period provided that:

- The Day Care Treatment is for Medically Necessary Treatment and follows the written advice of a Medical Practitioner;
- The Medical Expenses incurred are Reasonable and Customary ;

- We will only cover the Medical Expenses for those Day Care Treatments which are listed in Annexure II of this Policy. The complete list of Day Care Treatments covered is also available on Our website [www.kotakgeneralinsurance.com];
- We will not cover any OPD Treatment under this Benefit.

### 2.3 Pre-Hospitalisation Medical Expenses and Post Hospitalisation Medical Expenses

We will indemnify the Insured Person's Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses following an Illness or Injury that occurs during the Policy Period provided that:

- We have accepted a Claim for In-patient Treatment or Day Care Treatment under this Policy and the Pre-Hospitalisation Medical Expenses and/or Post-Hospitalisation Medical Expenses relate to the same Illness/medical condition;
- We will not be liable to pay Pre-Hospitalisation Medical Expenses for more than 30 days preceding the Insured Person's Admission to Hospital for In-patient Care or Day Care Treatment;
- We will not be liable to pay Post-Hospitalisation Medical Expenses for more than 60 days immediately following the Insured Person's discharge from Hospital following In-patient Care or Day Care Treatment.

### 2.4 Ambulance Cover

We will indemnify the Reasonable and Customary Charges incurred up to the limit specified in the Policy Schedule towards transportation of the Insured Person by a registered healthcare or Ambulance service provider to a Hospital for treatment of an Illness or Injury following an Emergency provided that:

- (a) The necessity of the use of the Ambulance is certified by the treating Medical Practitioner;
- (b) We will also provide cover under this Benefit if the Insured Person is required to be transferred from one Hospital to another Hospital or diagnostic center for advanced diagnostic treatment where such facility is not available at the existing Hospital or the Insured Person is required to be moved to a better Hospital facility due to lack of available / adequate treatment facilities at the existing Hospital.
- (c) The limit under Ambulance cover is applicable for each claim admitted under the policy.

### 2.5 Free Health Check-up

We will arrange for one free health check-up at Our Network Provider for each Insured Person that is above 18 years of Age, each Policy Year for the specified tests. Availing the Free Health Check-up will not impact the Base Annual Sum Insured or the Cumulative Bonus.

This will be offered regardless of any claim admitted/ registered in the Policy.

The present free health check-up will consist of the following tests for all eligible Insured Persons:

- (a) CBC;
- (b) MER;
- (c) Serum Cholesterol;
- (d) Serum Creatinine;
- (e) SGPT /SGOT;
- (f) ECG;
- (g) Random Blood Sugar;

### 2.6 Cumulative Bonus

We will increase Your Base Annual Sum Insured by 10% at the end of the Policy Year if the Policy is renewed with Us provided that;

- (a) If the Policy is a Family Floater Policy, then the Cumulative Bonus will accrue only if no claims have been made in respect of all the Insured Persons in the expiring Policy Year;
- (b) If the Policy is an Individual policy, then Cumulative Bonus will accrue only if no claim has been made in the expiring Policy Year in respect of that Insured Person;
- (c) The Cumulative Bonus under a Family Floater Policy will be available only to those Insured Persons who were Insured Persons in the immediately completed Policy Year;
- (d) If any Claim is made under the Policy after a Cumulative Bonus has been applied under the Policy, then the accrued Cumulative Bonus under the Policy will reduce by 10% on the commencement of the next Policy Year or the next Renewal of the Policy (as applicable);
- (e) The Cumulative Bonus will not accrue in excess of 50% of the Base Annual Sum Insured;
- (f) If the Base Annual Sum Insured is increased at the time of Renewal, then the Cumulative Bonus will be calculated based on the Base Annual Sum Insured of the immediately completed Policy Year;
- (g) If the Base Annual Sum Insured is reduced at the time of Renewal, then the applicable cumulative bonus will be applicable on the renewed policy Base Annual Sum Insured.
- (h) Cumulative bonus will be carried forward to the next policy year, provided the Insured Person renews the policy before the expiry of the grace period.
- (i) If the Policy Period is more than one year, then any Cumulative Bonus that has accrued for the Policy Year will be credited at the end of the Policy Year and shall be available for any claims made in the subsequent Policy Year.

### 3. WHAT WE WILL NOT PAY (EXCLUSIONS APPLICABLE UNDER THE POLICY)

We shall not be liable to make any payment under this Policy directly or indirectly for, caused by, based upon, arising out of or howsoever attributable to any of the exclusions listed below. All waiting periods will apply individually to each Insured Person:

#### 3.1 Pre-Existing Diseases (Code – Excl01)

- (a) Expenses related to the treatment of a pre-existing Disease (PED) and its direct complications shall be excluded until the expiry of 48 months of continuous coverage after the date of inception of the first policy with insurer.
- (b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- (c) If the Insured Person is continuously covered without any break as defined under the portability norms of the extant IRDAI (Health Insurance) Regulations, then waiting period for the same would be reduced to the extent of prior coverage.

- (d) Coverage under the policy after the expiry of 48 months for any pre-existing disease is subject to the same being declared at the time of application and accepted by Insurer.

#### 3.2 30 Day Waiting Period (Code – Excl03)

- (a) Expenses related to the treatment of any illness within 30 days from the first policy commencement date shall be excluded except claims arising due to an accident, provided the same are covered.
- (b) This exclusion shall not, however, apply if the Insured Person has Continuous Coverage for more than twelve months.
- (c) The within referred waiting period is made applicable to the enhanced sum insured in the event of granting higher sum insured subsequently.

#### 3.3 Specified disease/ procedure waiting period (Code – Excl02)

- (a) Expenses related to the treatment of the listed Conditions, surgeries/treatments shall be excluded until the expiry of 24 months of continuous coverage after the date of inception of the first policy with us. This exclusion shall not be applicable for claims arising due to an accident.
- (b) In case of enhancement of sum insured the exclusion shall apply afresh to the extent of sum insured increase.
- (c) If any of the specified disease/procedure falls under the waiting period specified for pre-Existing diseases, then the longer of the two waiting periods shall apply.
- (d) The waiting period for listed conditions shall apply even if contracted after the policy or declared and accepted without a specific exclusion.
- (e) If the Insured Person is continuously covered without any break as defined under the applicable norms on portability stipulated by IRDAI, then waiting period for the same would be reduced to the extent of prior coverage.
- (f) List of specific diseases/procedures
  - a. Cataract\*;
  - b. Benign Prostatic Hypertrophy;
  - c. Myomectomy, Hysterectomy unless because of malignancy;
  - d. All types of Hernia, Hydrocele;
  - e. Fissures and/or Fistula in anus, haemorrhoids/piles;
  - f. Arthritis, gout, rheumatism and spinal disorders;
  - g. Joint replacements unless due to Accident;
  - h. Sinusitis and related disorders;
  - i. Stones in the urinary and biliary systems;
  - j. Dilatation and curettage, Endometriosis;
  - k. All types of skin and internal tumors/ cysts/ nodules/ polyps of any kind including breast lumps unless malignant;
  - l. Dialysis required for chronic renal failure;
  - m. Surgery on Tonsillitis, adenoids and sinuses;
  - n. Gastric and duodenal erosions and ulcers;
  - o. Deviated nasal septum;
  - p. Varicose Veins/Varicose Ulcers.

\*Our maximum liability for any Claim for an Insured Person's cataract treatment shall not exceed INR 20,000 per eye, during each Policy Year of the Policy Period.

#### 3.4 Permanent Exclusions

- (a) **Investigation & Evaluation (Code- Excl04)**
  - (a) Expenses related to any admission primarily for diagnostics and evaluation purposes only are excluded.
  - (b) Any diagnostic expenses which are not related or not incidental to the current diagnosis and treatment are excluded
- (b) **Rest Cure, rehabilitation and respite care (Code – Excl05)**
  - (a) Expenses related to any admission primarily for enforced bed rest and not for receiving treatment. This also includes:
    - i. Custodial care either at home or in a nursing facility for personal care such as help with activities of daily living such as bathing, dressing, moving around either by skilled nurses or assistant or non-skilled persons.
    - ii. Any services for people who are terminally ill to address physical, social, emotional and spiritual needs.
- (c) **Obesity/ Weight Control (Code – Excl06)**
  - Expenses related to the surgical treatment of obesity that does not fulfil all the below conditions:

- 1) Surgery to be conducted is upon the advice of the Doctor
- 2) The surgery/Procedure conducted should be supported by clinical protocols
- 3) The member has to be 18 years of age or older and
- 4) Body Mass Index (BMI);
  - a) greater than or equal to 40 or
  - b) greater than or equal to 35 in conjunction with any of the following severe co-morbidities following failure of less invasive methods of weight loss:
    - i. Obesity-related cardiomyopathy
    - ii. Coronary heart disease
    - iii. Severe Sleep Apnea
    - iv. Uncontrolled Type 2 Diabetes
- (d) **Change of Gender treatments (Code – Excl07)**  
Expenses related to any treatment, including surgical management, to change characteristics of the body to those of the opposite sex.
- (e) **Cosmetic or plastic Surgery (Code – Excl08)**  
Expenses for cosmetic or plastic surgery or any treatment to change appearance unless for reconstruction following an Accident, Burn(s) or Cancer or as part of medically necessary treatment to remove a direct and immediate health risk to the insured. For this to be considered a medical necessity, it must be certified by the attending Medical Practitioner.
- (f) **Hazardous or Adventure sports: (Code- Excl09)**  
Expenses related to any treatment necessitated due to participation as a professional in hazardous or adventure sports, including but not limited to, para-jumping, rock climbing, mountaineering, rafting, motor racing, horse racing or scuba diving, hand gliding, sky diving, deep-sea diving.
- (g) **Breach of law (Code – Excl10)**  
Expenses for treatment directly arising from or consequent upon any Insured Person committing or attempting to commit a breach of law with criminal intent.
- (h) **Excluded Providers (Code- Excl11)**  
Expenses incurred towards treatment in any hospital or by any Medical Practitioner or any other provider specifically excluded by the Insurer and disclosed in its website / notified to the policyholders are not admissible. However, in case of life threatening situations or following an accident, expenses up to the stage of stabilization are payable but not the complete claim.
- (i) **Code- Excl12**  
Treatment for, Alcoholism, drug or substance abuse or any addictive condition and consequences thereof.
- (j) **Code- Excl13**  
Treatments received in health hydros, nature cure clinics, spas or similar establishments or private beds registered as a nursing home attached to such establishments or where admission is arranged wholly or partly for domestic reasons.
- (k) **Code- Excl14**  
Dietary supplements and substances that can be purchased without prescription, including but not limited to Vitamins, minerals and organic substances unless prescribed by a medical practitioner as part of hospitalization claim or day care procedure.
- (l) **Refractive Error (Code- Excl15)**  
Expenses related to the treatment for correction of eye sight due to refractive error less than 7.5 dioptries.
- (m) **Unproven Treatments (Code – Excl16)**  
Expenses related to any unproven treatment, services and supplies for or in connection with any treatment. Unproven treatments are treatments, procedures or supplies that lack significant medical documentation to support their effectiveness.
- (n) **Sterility and Infertility (Code- Excl17)**  
Expenses related to sterility and infertility. This includes:
  - i. Any type of contraception, sterilization
  - ii. Assisted Reproduction services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI
  - iii. Gestational Surrogacy
  - iv. Reversal of sterilization
- (o) **Maternity (Code- Excl18)**
  - i. Medical treatment expenses traceable to childbirth (including complicated deliveries and caesarean sections incurred during hospitalisation) except ectopic pregnancy
  - ii. Expenses towards miscarriage (unless due to an accident) and lawful medical termination of pregnancy during the policy period.
- (p) Costs of routine medical, eye or ear examinations preventive health check-ups, spectacles, laser surgery for correction of refractory errors, contact lenses, hearing aids, dentures or artificial teeth;
- (q) Any expenses incurred on prosthesis, corrective devices, external durable medical equipment of any kind, like wheelchairs, crutches, instruments used in treatment of sleep apnoea syndrome or continuous ambulatory peritoneal dialysis (C.A.P.D.) and oxygen concentrator for bronchial asthmatic condition, cost of cochlear implant(s) unless necessitated by an Accident or required intra-operatively;
- (r) Expenses incurred on all dental treatment unless necessitated due to an Accident;
- (s) Any expenses incurred on personal comfort, cosmetics, convenience and hygiene related items and services;
- (t) Any naturopathy treatment, acupuncture, magnetic and such other therapies;
- (u) Circumcision unless necessary for treatment of an Illness or necessitated due to an Accident;
- (v) Vaccination or inoculation of any kind, unless it is post animal bite;
- (w) Intentional self-injury (whether arising from an attempt to commit suicide or otherwise);
- (x) Treatment relating to Congenital external Anomalies;
- (y) any treatment related to sleep disorder or sleep apnoea syndrome, general debility, convalescence, run-down condition
- (z) Costs incurred for any health check-up or for the purpose of issuance of medical certificates and examinations required for employment or travel or any other such purpose;
- (aa) Any expenses arising out of Domiciliary Hospitalization; unless covered under extension 'Domiciliary hospitalization cover'
- (bb) Any treatment taken outside India;
- (cc) Any treatment taken from anyone not falling within the scope of definition of Medical Practitioner. Any treatment charges or fees charged by any Medical Practitioner acting outside the scope of licence or registration granted to him by any medical council;
- (dd) Expenses related to donor screening, treatment, including surgery to remove organs from a donor in the case of transplant surgery; unless covered under extension 'Donor Expenses'.
- (ee) Non- allopathic treatment; unless covered under extension 'Alternative treatment'
- (ff) Any consequential or indirect loss arising out of or related to Hospitalization;
- (gg) Any Injury or Illness directly or indirectly caused by or arising from or attributable to war, invasion, acts of foreign enemies, hostilities (whether war be declared or not), civil war, commotion, unrest, rebellion, revolution, insurrection, military or usurped power or confiscation or nationalisation or requisition of or damage by or under the order of any government or public local authority;
- (hh) Any Illness or Injury directly or indirectly caused by or contributed to by nuclear weapons/materials or contributed to by or arising from ionising radiation or contamination by radioactivity by any nuclear fuel or from any nuclear waste or from the combustion of nuclear fuel;
- (ii) All non-medical expenses listed in Annexure III (List I) of the Policy.
- (jj) Any physical, medical condition or treatment that is specifically excluded in the Policy Schedule under Important Conditions

#### 4. CLAIM ADMINISTRATION

The fulfillment of the terms and conditions of this Policy (including payment of premium by the due dates mentioned in the Policy Schedule) insofar as they relate to anything to be done or complied with by You or any Insured Person, including complying with the following in relation to claims, shall be conditions precedent to admission of Our liability under this Policy:

- (a) On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, the Claims Procedure set out below shall be followed;
- (b) If requested by Us and at Our cost, the Insured Person must submit to medical examination by Our nominated Medical Practitioner as often as We consider reasonable and necessary and We/Our representatives must be permitted to inspect the

medical and Hospitalisation records pertaining to the Insured Person's treatment and to investigate the facts surrounding the Claim;

- (c) We/Our representatives must be given all reasonable co-operation in investigating the claim in order to assess Our liability and quantum in respect of such Claim;
- (d) If the Insured Person suffers a relapse within 45 days of the date of discharge from Hospital for a Claim that has been made, then such Relapse shall be deemed to be part of the same Claim and all limits for Any One Illness under this Policy shall be applied as if they were part of a single claim.

## 5. CLAIMS PROCEDURE

On the occurrence or discovery of any Illness or Injury that may give rise to a Claim under this Policy, then as a condition precedent to Our liability under the Policy the following procedure shall be complied with:

### 5.1 For Cashless Facility

Cashless Facility is only available at a Network Provider. The complete list of Network Providers is available on Our website or can be obtained from Our call centre. In order to avail of Cashless Facility, the following procedure shall be followed:

#### (a) Pre-authorization for Planned Hospitalisation

At least 48 hours prior to a planned Hospitalisation, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that planned Hospitalisation. Each such request must be accompanied by all the following details:

- (i) The Health Card We have issued to the Insured Person;
- (ii) The Policy Number;
- (iii) Name of the Policyholder;
- (iv) Name and address of Insured Person in respect of whom the request is being made;
- (v) Nature of the Illness/Injury and the treatment/surgery required;
- (vi) Name and address of the attending Medical Practitioner;
- (vii) Hospital where treatment/surgery is proposed to be taken;
- (viii) Proposed date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorization specifying reasons for the rejection.

#### In Case of Claim Contact Us at:

**24x7 Toll Free number: 1800 266 4545 or may write and e-mail at care@kotak.com**

**In the event of claims, please send the relevant documents to: Family Health Plan (TPA) Ltd,**

**No: 8-2-269/A/2-1 To 6**

**2<sup>nd</sup> Floor, Srinilaya – Cyber Spazio**

**Road No. 2, Banjara Hills,**

**Hyderabad, 500 034.**

#### (b) Pre-authorization for Emergency Care

If the Insured Person has been admitted into Hospital for Emergency Care, We or Our TPA shall be contacted to request pre-authorization for availing the Cashless Facility for that Emergency Care within 24 hours of commencement of Hospitalisation. Each such request must be accompanied by all the following details:

- (i) The Health Card We have issued to the Insured Person;
- (ii) The Policy Number;
- (iii) Name of the Policyholder;
- (iv) Name and address of Insured Person in respect of whom the request is being made;
- (v) Nature of the Illness/Injury and the treatment/surgery required;
- (vi) Name and address of the attending Medical Practitioner;
- (vii) Hospital where treatment/surgery is being taken;
- (viii) Date of Admission.

If the foregoing information is not provided in full or is insufficient to ascertain the eligibility of the Claim under the Policy, then We/

Our TPA will request additional information or documentation in respect of that request.

Once there is sufficient information to assess the eligibility of the Claim under the Policy, We/Our TPA will issue the authorisation letter specifying the sanctioned amount, any specific limitation on the Claim and non-payable items, if applicable, or reject the request for pre-authorization specifying reasons for the rejection. In circumstances where We/Our TPA refuse the request for pre-authorization as there is insufficient Base Annual Sum Insured there is insufficient information to determine the admissibility of the request for pre-authorization, a claim for reimbursement may be submitted to Us in accordance with the procedure set out below and We will consider the Claim in accordance with the policy terms, conditions and exclusions.

We reserve the right to modify, add or restrict any Network Provider for Cashless Facilities in Our sole discretion. Before availing Cashless Facilities, please check the applicable updated list of Network Providers on Our website or by calling Our call centre.

### 5.2. For Reimbursement Claims

We shall be given written notice of the Claim for reimbursement along with the following details at least within 30 days of the Insured Person's discharge from Hospital:

- (a) The Policy Number;
- (b) Name of the Policyholder;
- (c) Name and address of the Insured Person in respect of whom the request is being made;
- (d) Nature of Illness or Injury and the treatment/surgery taken;
- (e) Name and address of the attending Medical Practitioner;
- (f) Hospital where treatment/surgery was taken;
- (g) Date of Admission and date of discharge;
- (h) Any other information that may be relevant to the Illness/ Injury/ Hospitalisation.

If the Claim is not notified to Us within 30 days of the Insured Person's discharge from Hospital, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

## 6. CLAIM DOCUMENTS

We shall be provided the following necessary information and documentation in respect of all Claims within 30 days of the Insured Person's discharge from Hospital. For Claims under which the use of Cashless Facility has been approved, We will be provided these documents by the Network Provider immediately following the Insured Person's discharge from Hospital:

- (a) Duly completed Claim form signed by You and the Medical Practitioner (only for reimbursement claims);
- (b) Original Pre – authorization request
- (c) Copy of Pre – authorization approval letter
- (d) Copy of the photo identity document of the Insured Person;
- (e) Original bills, receipts and discharge certificate/card from the Hospital/Medical Practitioner;
- (f) Original bills from chemists supported by proper prescription;
- (g) Original investigation test reports (including CT/MR/USG/ECG, as applicable) and payment receipts;
- (h) Indoor case papers;
- (i) Medical Practitioner's referral letter advising Hospitalisation in non-Accident cases and referral slip for all investigations carried out;
- (j) Hospital discharge summary;
- (k) FIR or MLC for Accident cases;
- (l) Post mortem report (if applicable and conducted);
- (m) Any other document as required by Us or Our TPA to investigate the Claim or Our obligation to make payment for it.

## 7. CLAIMS FOR PRE-HOSPITALISATION MEDICAL EXPENSES AND POST-HOSPITALISATION MEDICAL EXPENSES

- (a) All Claims for Pre-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the Insured Person's discharge from Hospital along with the following information and documentation:
  - (i) Duly Completed Claim Form
  - (ii) Investigation Payment Receipt
  - (iii) Original Investigation Report
  - (iv) Original Pharmacy Bills

(v) Original Pharmacy Prescription

(vi) Copy of Discharge Summary

(b) All Claims for Post-Hospitalisation Medical Expenses shall be submitted to Us within 30 days of the completion of post hospitalisation period as mentioned in your plan. You need to send Medical Expenses being incurred along with the following information and documentation:

(i) Duly Completed Claim Form

(ii) Investigation Payment Receipt

(iii) Original Investigation Report

(iv) Original Pharmacy Bills

(v) Original Pharmacy Prescription

(vi) Copy of Discharge Summary

(c) If the Claim is not notified to Us within these specified timeframes, then We shall be provided the reasons for the delay in writing. We will condone such delay on merits where the delay has been proved to be for reasons beyond the claimant's control.

#### 8. CLAIM SETTLEMENT (Provision for Penal Interest)

i. The Company shall settle or reject a claim, as the case may be, within 30 days from the date of receipt of last necessary document.

ii. In the case of delay in the payment of a claim, the Company shall be liable to pay interest to the policyholder from the date of receipt of last necessary document to the date of payment of claim at a rate 2% above the bank rate.

iii. However, where the circumstances of a claim warrant an investigation in the opinion of the Company, it shall initiate and complete such investigation at the earliest, in any case not later than 30 days from the date of receipt of last necessary document. In such cases, the Company shall settle or reject the claim within 45 days from the date of receipt of last necessary document.

iv. In case of delay beyond stipulated 45 days, the Company shall be liable to pay interest to the policyholder at a rate 2% above the bank rate from the date of receipt of last necessary document to the date of payment of claim.

(Explanation: "Bank rate" shall mean the rate fixed by the Reserve Bank of India (RBI) at the beginning of the financial year in which claim has fallen due)

### PART III OF THE POLICY

#### General Terms and Conditions

##### 1. Disclosure of Information

The policy shall be void and all premium paid thereon shall be forfeited to the Company in the event of misrepresentation, mis description or non-disclosure of any material fact by the policyholder.

(Explanation: "Material facts" for the purpose of this policy shall mean all relevant information sought by the company in the proposal form and other connected documents to enable it to take informed decision in the context of underwriting the risk)

##### 2. Reasonable Care

You/Insured Persons shall take all reasonable steps to safeguard Your/Insured Person's interests against any Injury or Illness that may give rise to the any claim under the Policy.

##### 3. Condition Precedent to Admission of Liability

The terms and conditions of the policy must be fulfilled by the insured person for the Company to make any payment for claim(s) arising under the policy.

##### 4. Complete Discharge

Any payment to the policyholder, insured person or his/ her nominees or his/ her legal representative or assignee or to the Hospital, as the case may be, for any benefit under the policy shall be a valid discharge towards payment of claim by the Company to the extent of that amount for the particular claim.

##### 5. Material Change

Material information to be disclosed to Us includes every matter that You are aware of or could reasonably be expected to know that relates to questions in the Proposal Form and which is relevant to Us in order to accept the risk and the terms of acceptance of the risk.

##### 6. Records to be maintained

You shall keep an accurate record containing all relevant medical records and shall allow Us to inspect such records. You shall exercise all necessary co-operation in obtaining the medical

records from the Hospital, and furnish them, as We may require in relation to the Claim within 30 days of such request from Us.

##### 7. No constructive Notice

Any knowledge or information of any circumstances or condition in Your connection in possession of any of Our personnel and not specifically informed to Us by You shall not be held to bind or prejudicially affect Us notwithstanding subsequent acceptance of any premium.

##### 8. Overriding effect of Part II of the Policy

The terms and conditions contained herein and in Part II of the Policy shall be deemed to form part of the Policy and shall be read as if they are specifically incorporated herein; however in case of any inconsistency of any term and condition with the scope of cover contained in Part II of the Policy, then the term(s) and condition(s) contained herein shall be read mutatis mutandis with the scope of cover/terms and conditions contained in Part II of the Policy and shall be deemed to be modified accordingly or superseded in case of inconsistency being irreconcilable.

##### 9. Multiple Policies

i. In case of multiple policies taken by an insured person during a period from one or more insurers to indemnify treatment costs, the insured person shall have the right to require a settlement of his/her claim in terms of any of his/her policies. In all such cases the insurer chosen by the insured person shall be obliged to settle the claim as long as the claim is within the limits of and according to the terms of the chosen policy.

ii. Insured person having multiple policies shall also have the right to prefer claims under this policy for the amounts disallowed under any other policy / policies even if the sum insured is not exhausted. Then the insurer shall independently settle the claim subject to the terms and conditions of this policy.

iii. If the amount to be claimed exceeds the sum insured under a single policy, the insured person shall have the right to choose insurer from whom he/she wants to claim the balance amount.

iv. Where an insured person has policies from more than one insurer to cover the same risk on indemnity basis, the insured person shall only be indemnified the treatment costs in accordance with the terms and conditions of the chosen policy.

##### 10. Fraud

If any claim made by the insured person, is in any respect fraudulent, or if any false statement, or declaration is made or used in support thereof, or if any fraudulent means or devices are used by the insured person or anyone acting on his/her behalf to obtain any benefit under this policy, all benefits under this policy and the premium paid shall be forfeited.

Any amount already paid against claims made under this policy but which are found fraudulent later shall be repaid by all recipient(s)/policyholder(s), who has made that particular claim, who shall be jointly and severally liable for such repayment to the insurer.

For the purpose of this clause, the expression "fraud" means any of the following acts committed by the insured person or by his agent or the hospital/doctor/any other party acting on behalf of the insured person, with intent to deceive the insurer or to induce the insurer to issue an insurance policy:

a) the suggestion, as a fact of that which is not true and which the insured person does not believe to be true;

b) the active concealment of a fact by the insured person having knowledge or belief of the fact;

c) any other act fitted to deceive; and

d) any such act or omission as the law specially declares to be fraudulent

The Company shall not repudiate the claim and / or forfeit the policy benefits on the ground of Fraud, if the insured person / beneficiary can prove that the misstatement was true to the best of his knowledge and there was no deliberate intention to suppress the fact or that such misstatement of or suppression of material fact are within the knowledge of the insurer.

##### 11. Limitation of Liability

If a Claim is rejected or partially settled under the terms of the Policy and is not the subject of a pending suit or other proceedings within the applicable period specified under the Limitation Act 1963 (as amended and any other applicable law), the Claim shall be deemed to have been abandoned and Our liability in respect of it shall be extinguished.



## 12. Underwriting and Loadings

We may apply a risk loading up to a maximum 100% per Insured Person, on the premium payable (excluding statutory levies & taxes) based on declarations on proposal form, your health status. Loadings will be applied from Inception Date of the first Policy including subsequent renewal(s). There will be no loadings based on individual claims experience.

We will inform You about the applicable risk loading or special condition through a counter offer letter and We will only issue the Policy once We receive your consent on the applicable additional premium.

In case of loading on 2 or more ailments, the loadings shall apply in conjunction, however maximum risk loading per individual shall not exceed 100% of Premium excluding applicable Taxes. In case policies accepted with loadings, waiting period for Pre-existing disease's as well as 2 year waiting period shall be applicable.

In case policies accepted with loadings, waiting period for Pre-Existing Disease Waiting Period (Section 3.1) as well as 2 Year Waiting Period (Section 3.3) shall continue to be applicable.

## 13. Free Look Period

The Free Look Period shall be applicable on new individual health insurance policies and not on renewals or at the time of porting/migrating the policy.

The insured person shall be allowed free look period of fifteen days from date of receipt of the policy document to review the terms and conditions of the policy, and to return the same if not acceptable.

If the insured has not made any claim during the Free Look Period, the insured shall be entitled to

- i. a refund of the premium paid less any expenses incurred by the Company on medical examination of the insured person and the stamp duty charges or
- ii. where the risk has already commenced and the option of return of the policy is exercised by the insured person, a deduction towards the proportionate risk premium for period of cover or
- iii. Where only a part of the insurance coverage has commenced, such proportionate premium commensurate with the insurance coverage during such period;

## 14. Cancellation

- i. The policyholder may cancel this policy by giving 15 days' written notice and in such an event, the Company shall refund premium for the unexpired policy period as detailed below.

For Policyholder's initiated cancellation, the Company would compute refund amount as pro-rata (for the unexpired duration) premium further deducted by 25% of computed refundable premium towards management expenses.

Notwithstanding anything contained herein or otherwise, no refunds of premium shall be made in respect of Cancellation where, any claim has been admitted or has been lodged or any benefit has been availed by the insured person under the policy.

- ii. The Company may cancel the policy at any time on grounds of misrepresentation non-disclosure of material facts, fraud by the insured person by giving 15 days' written notice. There would be no refund of premium on cancellation on grounds of misrepresentation, non-disclosure of material facts or fraud.

## 15. Cause of Action/ Currency for payments

No Claims shall be payable under this Policy unless the cause of action arises in India, unless otherwise specifically provided in Policy. All Claims shall be payable in India and shall be in Indian Rupees only.

## 16. Policy Disputes

Any dispute concerning the interpretation of the terms, conditions, limitations and/or exclusions contained herein is understood and agreed by both You and Us to be adjudicated or interpreted in accordance with Indian law and only competent Courts of India shall have the exclusive jurisdiction to try all or any matters arising hereunder. The matter shall be determined or adjudicated in accordance with the law and practice of such Court.

## 17. Portability

The insured person will have the option to port the policy to other insurers by applying to such insurer to port the entire policy along with all the members of the family, if any, at least 45 days before, but not earlier than 60 days from the policy renewal date as per IRDAI guidelines related to portability. If such person is presently covered and has been continuously covered without any lapses under any health insurance policy with an Indian General/Health insurer, the proposed insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on portability.

For Detailed Guidelines on Portability,

kindly refer: IRDAI/HLT/REG/CIR/003/01/2020

## 18. Migration

The insured person will have the option to migrate the policy to other health insurance products/plans offered by the company by applying for migration of the policy at least 30 days before the policy renewal date as per IRDAI guidelines on Migration. If such person is presently covered and has been continuously covered without any lapses under any health insurance product/plan offered by the company, the insured person will get the accrued continuity benefits in waiting periods as per IRDAI guidelines on migration.

For Detailed Guidelines on Migration,

kindly refer: IRDAI/HLT/REG/CIR/003/01/2020

## 19. Renewal of Policy

The policy shall ordinarily be renewable except on grounds of fraud, misrepresentation by the insured person.

- i. The Company shall endeavor to give notice for renewal. However, the Company is not under obligation to give any notice for renewal.
- ii. Renewal shall not be denied on the ground that the insured person had made a claim or claims in the preceding policy years.
- iii. Request for renewal along with requisite premium shall be received by the Company before the end of the policy period.
- iv. At the end of the policy period, the policy shall terminate and can be renewed within the Grace Period of at least 30 days to maintain continuity of benefits without break in policy. Coverage is not available during the grace period.
- v. No loading shall apply on renewals based on individual claims experience.

## 20. Withdrawal of Policy

- i. In the likelihood of this product being withdrawn in future, the Company will intimate the insured person about the same 90 days prior to expiry of the policy.
- ii. Insured Person will have the option to migrate to similar health insurance product available with the Company at the time of renewal with all the accrued continuity benefits such as cumulative bonus, waiver of waiting period as per IRDAI guidelines, provided the policy has been maintained without a break.

## 21. Special Provision for Insured Person who are Senior citizen

The premium charged for health Insurance products offered to Senior citizens shall be fair, justified, transparent and duly disclosed upfront.

The insured shall be informed in writing of any underwriting loading charged over and above the premium and the specific consent of the policyholder for such loadings shall be obtained before issuance of policy.

## 22. Communications & Notices

Any communication, notice, direction or instruction given under this Policy shall be in writing and delivered by hand, post, or facsimile to:

In Your case, at Your last known address per Our records in respect of this Policy.

In Our case, at Our address specified in the Policy Schedule.

No insurance agent, broker or any other person is authorised to receive any notice on Our behalf.

## 23. Customer Service

If at any time You require any clarification or assistance, You may contact Our offices at the address specified in the Policy Schedule, during normal business hours or contact Our call centre.

## 24. ECS/ Auto Debit Payment Facility

You are eligible for availing the ECS / Auto Debit payment facility for your premium payments under this Policy. This facility can be opted for automatic premium payment under this Policy for such premium paying term as availed by you under this Policy by submitting a duly signed ECS / Auto Debit mandate form. You may opt for any premium payment term as per your convenience but in accordance with the Policy terms and conditions. Please note that this facility may not be available for all the Banks at present however and you are requested to kindly visit website: [www.kotakgeneralinsurance.com](http://www.kotakgeneralinsurance.com) to check the updated list of all partner banks facilitating the ECS/Auto Debit facility from time to time. Additionally, the following conditions shall apply in case of ECS / Auto Debit facility opted by you

- a. The premium payment under the Policy shall be subject to change on renewal which would be in accordance with the terms and conditions of the Policy
- b. The Policy shall get cancelled in the event of failure of ECS

transaction towards payment of premium under the Policy and/or non-receipt of premium within the Grace Period under the Policy

- c. The renewal premium amount under the Policy shall be communicated to you in advance i.e. minimum 45 days before the renewal date
- d. You have the right to withdraw the ECS /Auto Debit mandate by giving Us at least 15 days' notice before the due date of next premium due under the Policy

The term ECS / Auto Debit herein shall be governed by the Electronic Clearing Service (Debit) Procedural Guidelines issued by the Reserve Bank of India (as may be amended from time to time) and shall mean an electronic facility for effecting periodic insurance premium payment transactions in an automated manner.

**25. Possibility of Revision of Terms of the Policy Including the Premium Rates**

The Company, with prior approval of IRDAI, may revise or modify the terms of the policy including the premium rates. The insured person shall be notified three months before the changes are effected.

**26. Moratorium Period**

After completion of eight continuous years under the Policy no look back to be applied. This period of eight years is called as moratorium period. The moratorium would be applicable for the sums insured of the first Policy and subsequently completion of 8 continuous years would be applicable from date of enhancement of sums insured only on the enhanced limits. After the expiry of Moratorium Period no health insurance claim shall be contestable except for proven fraud and permanent exclusions specified in the Policy contract. The policies would however be subject to all limits, sub limits, co-payments, deductibles as per the Policy contract.

**27. Nomination**

The policyholder is required at the inception of the policy to make a nomination for the purpose of payment of claims under the policy in the event of death of the policyholder. Any change of nomination shall be communicated to the company in writing and such change shall be effective only when an endorsement on the policy is made. In the event of death of the policyholder, the Company will pay the nominee {as named in the Policy Schedule/Policy Certificate /

Endorsement(if any)) and in case there is no subsisting nominee, to the legal heirs or legal representatives of the policyholder whose discharge shall be treated as full and final discharge of its liability under the policy.

**28. Redressal of Grievance**

In case of any grievance the insured person may contact the company through Website: [www.kotakgeneralinsurance.com](http://www.kotakgeneralinsurance.com)

Toll free: 18002664545

E-mail: [care@kotak.com](mailto:care@kotak.com), Fax: 022-28401823

Courier: Kotak General Insurance 2nd Floor, Zone II, Building No.21, Infinity IT park, Off Western Express Highway, Goregaon, Mulund Link Road, Malad (E), Mumbai - 400097.

Insured person may also approach the grievance cell at any of the company's branches with the details of grievance If Insured person is not satisfied with the redressal of grievance through one of the above methods, insured person may contact the grievance officer at [grievanceofficer@kotak.com](mailto:grievanceofficer@kotak.com)

For updated details of grievance officer, kindly refer the link: <https://www.kotakgeneralinsurance.com/customer-support/grievance-redressal-process>

For senior citizens, please contact the respective branch office of the Company or call at 18002664545 or may write an e- mail at [seniorcitizen@kotak.com](mailto:seniorcitizen@kotak.com)

If Insured person is not satisfied with the redressal of grievance through above methods, the insured person may also approach the office of Insurance Ombudsman of the respective area/region for redressal of grievance as per Insurance Ombudsman Rules 2017.

The details of the Insurance Ombudsman is available at:

<https://www.kotakgeneralinsurance.com/customer-support/grievance-redressal-process>

The updated details of Insurance Ombudsman offices are also available on the website of Executive Council of Insurers: [www.ecoi.co.in/ombudsman.html](http://www.ecoi.co.in/ombudsman.html)

The details of the Insurance Ombudsman is available at Annexure I Grievance may also be lodged at IRDAI Integrated Grievance Management System <https://igms.irda.gov.in/>

**Annexure I - Details of Insurance Ombudsman**

Office Details	Jurisdiction of Office Union Territory, District
Ahmedabad: Office of the Insurance Ombudsman, 6th Floor, Jeevan Prakash Bldg, Tilak Marg, Relief Road, Ahmedabad - 380001. Tel.: 079 – 25501201/02/05/06 Email: <a href="mailto:bimalokpal.ahmedabad@ecoi.co.in">bimalokpal.ahmedabad@ecoi.co.in</a>	Gujarat, Dadra & Nagar Haveli, Daman and Diu.
Bengaluru: Office of the Insurance Ombudsman, Jeevan Soudha Building, PID No. 57-27-N-19 Ground Floor, 19/19, 24th Main Road, JP Nagar, 1st Phase, Bengaluru – 560 078. Tel.: 080 - 26652048 / 26652049. Email: <a href="mailto:bimalokpal.bengaluru@ecoi.co.in">bimalokpal.bengaluru@ecoi.co.in</a>	Karnataka.
Bhopal: Office of the Insurance Ombudsman, Janak Vihar Complex, 2nd Floor, 6, Malviya Nagar, Opp. Airtel, Near New Market, BHOPAL(M.P.)- 462003 Tel.:- 0755-2769201 / 2769202, Fax : 0755-2769203. Email: <a href="mailto:bimalokpal.bhopal@ecoi.co.in">bimalokpal.bhopal@ecoi.co.in</a>	Madhya Pradesh and Chattisgarh.
Bhubneshwar: Office of the Insurance Ombudsman, 62, Forest park, Bhubneshwar – 751 009.Tel.: 0674 - 2596461 /2596455, Fax: 0674 - 2596429, Email: <a href="mailto:bimalokpal.bhubaneswar@ecoi.co.in">bimalokpal.bhubaneswar@ecoi.co.in</a>	Orissa.
Chandigarh: Office of the Insurance Ombudsman, S.C.O. No. 101, 102 & 103, 2nd Floor, Batra Building, Sector 17 – D, Chandigarh – 160 017. Tel.: 0172 - 2706196 / 2706468, Fax: 0172 - 2708274 Email: <a href="mailto:bimalokpal.chandigarh@ecoi.co.in">bimalokpal.chandigarh@ecoi.co.in</a>	Punjab, Haryana,Himachal Pradesh, Jammu & Kashmir, Chandigarh.
Chennai: Office of the Insurance Ombudsman, Fatima Akhtar Court, 4th Floor, 453,Anna Salai, Teynampet, CHENNAI – 600 018. Tel.: 044 - 24333668 / 24335284, Fax: 044 - 24333664. Email: <a href="mailto:bimalokpal.chennai@ecoi.co.in">bimalokpal.chennai@ecoi.co.in</a>	Tamil Nadu, Pondicherry Town and Karaikal (which are part of Pondicherry).
New Delhi: Office of the Insurance Ombudsman, 2/2 A, Universal Insurance Building, Asaf Ali Road, New Delhi – 110 002. Tel.: 011 - 23239633 / 23237532 Fax: 011 - 23230858 Email: <a href="mailto:bimalokpal.delhi@ecoi.co.in">bimalokpal.delhi@ecoi.co.in</a>	Delhi
Guwahati: Office of the Insurance Ombudsman, Jeevan Nivesh, 5th Floor, Nr. Panbazar over bridge, S.S. Road, Guwahati – 781001 (ASSAM). Tel.: 0361 - 2132204 / 2132205, Fax: 0361 - 2732937 Email: <a href="mailto:bimalokpal.guwahati@ecoi.co.in">bimalokpal.guwahati@ecoi.co.in</a>	Assam, Meghalaya, Manipur, Mizoram, Arunachal Pradesh, Nagaland and Tripura.
Hyderabad: Office of the Insurance Ombudsman, 6-2-46, 1st floor, "Moin Court", Lane Opp. Saleem Function Palace, A. C. Guards, Lakdi-Ka-Pool, Hyderabad - 500 004. Tel.: 040 - 65504123 / 23312122, Fax: 040 - 23376599 Email: <a href="mailto:bimalokpal.hyderabad@ecoi.co.in">bimalokpal.hyderabad@ecoi.co.in</a>	Andhra Pradesh, Telangana, Yanam and part of Territory of Pondicherry.
Jaipur: Office of the Insurance Ombudsman, Jeevan Nidhi – II Bldg., Gr. Floor, Bhawani Singh Marg, Jaipur - 302 005. Tel.: 0141 - 2740363, Email: <a href="mailto:bimalokpal.jaipur@ecoi.co.in">bimalokpal.jaipur@ecoi.co.in</a>	Rajasthan.
Ernakulam: Office of the Insurance Ombudsman, 2nd floor, Pulinat Building, Opp. Cochin Shipyard, M.G. Road, Ernakulam - 682 015. Tel.:- 0484-2358759 / 2359338, Fax:- 0484-2359336, Email: <a href="mailto:bimalokpal.ernakulam@ecoi.co.in">bimalokpal.ernakulam@ecoi.co.in</a>	Kerala, Lakshadweep, Mahe-a part of Pondicherry.
Kolkata: Office of the Insurance Ombudsman, Hindustan Bldg. Annexe, 4th Floor, 4, C.R. Avenue, KOLKATA - 700 072. Tel.: 033 - 22124339 / 22124340, Fax : 033 - 22124341, Email: <a href="mailto:bimalokpal.kolkata@ecoi.co.in">bimalokpal.kolkata@ecoi.co.in</a>	West Bengal, Sikkim, Andaman & Nicobar Islands.

Lucknow: Office of the Insurance Ombudsman, 6th Floor, Jeevan Bhawan, Phase-II, Nawal Kishore Road, Hazratganj, Lucknow - 226 001. Tel.: 0522 - 2231330 / 2231331 Fax: 0522 - 2231310 . Email: bimalokpal.lucknow@ecoi.co.in	Districts of Uttar Pradesh: Laitpur, Jhansi, Mahoba, Hamirpur, Banda, Chitrakoot, Allahabad, Mirzapur, Sonbhadra, Fatehpur, Pratapgarh, Jaunpur, Varanasi, Gazipur, Jalaun, Kanpur, Lucknow, Unnao, Sitapur, Lakhimpur, Bahraich, Barabanki, Raebareli, Sravasti, Gonda, Faizabad, Amethi, Kaushambi, Balrampur, Basti, Ambedkarnagar, Sultanpur, Maharajgang, Santkabirnagar, Azamgarh, Kushinagar, Gorkhpur, Deoria, Mau, Ghazipur, Chandauli, Ballia, Sidharathnagar.
Mumbai: Office of the Insurance Ombudsman, 3rd Floor, Jeevan Seva Annexe, S. V. Road, Santacruz (W), Mumbai - 400 054. Tel.: 022 - 26106552 / 26106960 Fax: 022 - 26106052. Email: bimalokpal.mumbai@ecoi.co.in	Goa, Mumbai Metropolitan Region excluding Navi Mumbai & Thane
Noida: Office of the Insurance Ombudsman, Bhagwan Sahai Palace, 4th Floor, Main Road, Naya Bans, Sector-15, Distt: Gautam Buddh Nagar, Noida, U.P-201301. Tel.: 0120-2514250/2514252/2514253. Email:- bimalokpal.noida@ecoi.co.in	State of Uttaranchal and the following Districts of Uttar Pradesh: Agra, Aligarh, Bagpat, Bareilly, Bijnor, Budaun, Bulandshahr, Etah, Kanooj, Mainpuri, Mathura, Meerut, Moradabad, Muzaffarnagar, Oraiyya, Pilibhit, Etawah, Farrukhabad, Firozbad, Gautambodhanagar, Ghaziabad, Hardoi, Shahjahanpur, Hapur, Shamli, Rampur, Kashganj, Sambhal, Amroha, Hathras, Kanshiramnagar, Saharanpur.
Patna: Office of the Insurance Ombudsman, 1st Floor, Kalpana Arcade Building, Bazar Samiti Road, Bahadurpur, Patna - 800 006. Tel.: 0612-2680952. Email:- bimalokpal.patna@ecoi.co.in	Bihar and Jharkhand.
Pune: Office of the Insurance Ombudsman, Jeevan Darshan Bldg., 3rd Floor, C.T.S. No.s 195 to 198, N.C. Kelkar Road, Narayan Peth, Pune - 411 030. Tel.: 020 - 41312555. Email: bimalokpal.pune@ecoi.co.in	Maharashtra, Area of Navi Mumbai and Thane excluding Mumbai Metropolitan Region.

## EXTENSIONS/ ENDORSEMENTS WORDINGS

The following Optional Extensions/Endorsements (offered under packs/ individual basis) applicable under the Policy only if We have received the applicable premium due for that Extension/Endorsement in full and the Policy Schedule specifies that the Extension/Endorsement is in force for the Insured Person.

Benefits under the Extension/Endorsement will be applicable subject to the terms, conditions and exclusions of the Extension/Endorsement, the terms, conditions and exclusions of the Policy and the availability of Base Annual Sum Insured and Cumulative Bonus and subject always to any sub-limits specified in respect of that Extension/Endorsement and any limits applicable under the Plan in force for the Insured Person as specified in the Policy Schedule.

### Extension HC 1 - Hospital Daily Cash

We will pay the Daily Cash Amount specified in the Policy Schedule for this Extension for each and every completed day of the Insured Person's Hospitalisation during the Policy Period provided that:

- We have accepted a Claim for In-patient Treatment under the Policy;
- The Insured Person's Hospitalisation extends for at least 3 consecutive days, in which case We will make payment under this Extension from the first day of Hospitalisation.
- We shall not be liable to make payment for more than the maximum number of days per policy year specified in the Policy Schedule for this Extension.
- This benefit is applicable on an individual basis irrespective of type of policy (Individual/floater).
- The payment under this benefit is over and above the opted Base Annual Sum Insured.

### Extension HC 2 - Convalescence Benefit

We will pay the amount specified in the Policy Schedule for this Extension if the Insured Person is Admitted in Hospital for a minimum period of 10 consecutive days provided that:

- We have accepted a Claim for In-patient Treatment under the Policy in respect of the same Hospitalisation;
- We shall not be liable to make payment under this Extension in respect of an Insured Person more than once during the Policy Year.
- This benefit is applicable on an individual basis irrespective of type of policy (Individual/floater).
- The payment under this benefit is over and above the opted Base Annual Sum Insured.

following an Illness or Injury that occurs during the Policy Period up to the limits of the opted Base Annual Sum Insured (subject to availability of opted Base Annual Sum Insured), provided that:

- We will cover medical expenses of an Insured person for treatment of a disease, illness or injury taken at home which would otherwise have required hospitalisation or since the Insured person's condition did not allow a hospital transfer or a hospital bed was unavailable. This is provided that the condition for which treatment is required continues for at least 3 days and is on the advice of a medical practitioner.
- The domiciliary Hospitalisation is Medically Necessary and follows the written advice of a Medical Practitioner
- The Medical Expenses incurred are Reasonable and Customary Charges;
- The Insured Person's Domiciliary Hospitalisation extends for at least 3 consecutive days in which case We will pay Medical Expenses under this Extension from the first day of Domiciliary Hospitalisation;
- In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.
- The payment under this benefit is within the opted Base Annual Sum Insured.
- We will not indemnify any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses under this Extension;
- We shall not indemnify any Medical Expenses incurred for the treatment of any of the following Illnesses/conditions:
  - Asthma;
  - Bronchitis;
  - Chronic Nephritis and Chronic Nephritic Syndrome;
  - Diarrhoea and all types of Dysenteries including Gastro-enteritis;
  - Diabetes Mellitus and Insipidus;
  - Epilepsy;
  - Hypertension;
  - Influenza, cough and cold;
  - All psychiatric or psychosomatic disorders;
  - Pyrexia of unknown origin for less than 10 days;
  - Tonsillitis and Upper Respiratory Tract Infection including Laryngitis and Pharyngitis;
  - Arthritis, Gout and Rheumatism.

### Extension HC 3 - Domiciliary Hospitalisation Cover

We will indemnify the Medical Expenses incurred on the Insured Person's Domiciliary Hospitalisation during the Policy Period

Exclusion 3.4 (aa) of the Policy Wordings stands deleted to the extent of this Extension only.

#### **Extension HC 4 - Donor Expenses**

We will indemnify the In-patient Hospitalisation Medical Expenses towards the donor for harvesting the organ up to the limits of the opted Base Annual Sum Insured (subject to availability of opted Base Annual Sum Insured), provided that:

- a. The organ donor is any person in accordance with the Transplantation of Human Organs Act 1994 (amended) and other applicable laws and rules;
- b. The organ donated is for the use of the Insured Person who has been asked to undergo an organ transplant on Medical Advice;
- c. We have accepted a Claim for In-patient Treatment under the Policy in respect of the Insured Person;
- d. In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.
- e. The payment under this benefit is within the opted Base Annual Sum Insured.
- f. We will not cover expenses towards the donor in respect of:
  - (i) Any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses;
  - (ii) Costs directly or indirectly associated to the acquisition of the organ;
  - (iii) Any other medical treatment or complication in respect of the donor, consequent to harvesting.

Exclusion 3.4 (dd) of the Policy Wordings stands deleted to the extent of this Extension only.

#### **Extension HC 5 - Alternative Treatment**

We will indemnify the Medical Expenses incurred on the Insured Person's Alternative Treatment up to INR 50,000/- (subject to availability of opted Base Annual Sum Insured), provided that:

- (a) The Alternative Treatment is administered by a Medical Practitioner;
- (b) The Insured Person is admitted to Hospital as an Inpatient for the Alternative Treatment to be administered.
- (c) In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.
- (d) The payment under this benefit is within the opted Base Annual Sum Insured.

Exclusion 3.4 (ee) of the Policy stands deleted to the extent of this Extension only.

#### **Extension HC 6 - Critical Illness Cover**

If the Insured Person is first diagnosed to be suffering from any of the following Critical Illnesses during the Policy Period, We will pay the Critical Illness Sum Insured specified in the Policy Schedule for this Extension, provided that:

- (a) On payment of additional premium, cover would be provided to each individual on the opted limit of amount (Sum Insured) for the policy period. This cover would be applicable on individual sum insured basis;
- (b) We shall not be liable to accept any Claim under this Extension if it pertains to any Critical Illness diagnosed within 90 days of the commencement of the first Policy Period of this Extension with Us;
- (c) We shall not be liable to make payment under this Extension more than once in respect of any Insured Person across all Policy Periods;
- (d) Payment under this Extension will not impact the opted Base Annual Sum Insured or the Cumulative Bonus (if any).
- (e) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ floater).
- (f) The payment under this benefit is over and above the opted Base Annual Sum Insured.
- (g) Once a claim has been accepted and paid for a particular Critical illness, this extension shall cease in respect of that Insured Person, but shall continue to be in force for other Insured Persons.
- (h) Notwithstanding any provision to the contrary in the Policy, under this Extension alone We will cover Claims occurring worldwide;
- (i) In the event of a Claim arising under this Extension, We shall be

given written notice of the Claim within 30 days from the date of the first diagnosis of the Critical Illness and We shall be provided the following information and documentation:

- i) The Claim documents stated in the Policy, provided that We will accept duly certified copies of the listed documents if the originals are required to be submitted to any other insurance company;
- ii) Written confirmation of the diagnosis of the Critical Illness from the treating Medical Practitioner;

"Critical Illness" for the purpose of this Extension means the following:

#### **1) CANCER OF SPECIFIED SEVERITY**

- (i) A malignant tumor characterized by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must be supported by histological evidence of malignancy. The term cancer includes leukemia, Lymphoma and Sarcoma.
- (ii) The following are excluded -
  - i. All Tumours which are histologically described as carcinoma in situ, benign, pre-malignant, borderline malignant, low malignant potential, neoplasm of unknown behaviour or non-invasive, including but not limited to: Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN-2 & CIN-3.
  - ii. Any non-melanoma skin carcinoma unless there is evidence of metastases to lymph nodes or beyond;
  - iii. Malignant melanoma that has not caused invasion beyond the epidermis
  - iv. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
  - v. All Thyroid cancers histologically classified as T1N0M0 (TNM Classification) or below
  - vi. Chronic lymphocytic leukaemia less than RAI stage 3
  - vii. Non-invasive papillary cancer of the bladder histologically described as TaN0M0 or of a lesser classification
  - viii. All Gastro-Intestinal Stromal Tumors histologically classified as T1N0M0 (TNM Classification) or below and with mitotic count of less than or equal to 5/50 HPFs
  - ix. All tumours in the presence of HIV infection.

#### **2) OPEN CHEST CABG**

- (a) The actual undergoing of heart surgery to correct blockage or narrowing in one or more coronary artery(s), by coronary artery bypass grafting done via a sternotomy (cutting through the breast bone) or minimally invasive keyhole coronary artery bypass procedures. The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a cardiologist.
- (b) The following are excluded:
  - i. Angioplasty and/or any other intra-arterial procedures

#### **3) MYOCARDIAL INFARCTION (FIRST HEART ATTACK - OF SPECIFIC SEVERITY)**

- (a) The first occurrence of heart attack or myocardial infarction, which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for Myocardial Infarction should be evidenced by all of the following criteria:
  - i. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
  - ii. New characteristic electrocardiogram changes
  - iii. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.
- (b) The following are excluded:
  - i. Other acute Coronary Syndromes
  - ii. Any type of angina pectoris.
  - iii. A rise in cardiac biomarkers or Troponin T or I in absence of overt ischemic heart disease OR following an intra-arterial cardiac procedure

#### **4) KIDNEY FAILURE REQUIRING REGULAR DIALYSIS**

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular Renal Dialysis (Hemodialysis or Peritoneal Dialysis) is instituted or Renal Transplantation is carried out. Diagnosis has to be

confirmed by a specialist medical practitioner.

**5) MAJOR ORGAN /BONE MARROW TRANSPLANT**

(a) The actual undergoing of a transplant of:

- i. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
- ii. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

(b) The following are excluded:

- a. Other stem-cell transplants
- b. Where only islets of langerhans are transplanted

**6) STROKE RESULTING IN PERMANENT SYMPTOMS**

(a) Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

(b) The following are excluded:

- i. Transient ischemic attacks (TIA)
- ii. Traumatic injury of the brain
- iii. Vascular disease affecting only the eye or optic nerve or vestibular functions.

**7) PERMANENT PARALYSIS OF LIMBS**

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

**8) OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES**

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echo cardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/ valvuloplasty are excluded.

**9) COMA OF SPECIFIED SEVERITY**

(a) A state of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

- (i) No response to external stimuli continuously for at least 96 hours;
- (ii) Life support measures are necessary to sustain life; and
- (iii) Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

(b) The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

**10) MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS**

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

**11) MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS**

1. The unequivocal diagnosis of definite multiple sclerosis confirmed and evidenced by all of the following:

- a. investigations including typical MRI findings, which unequivocally confirm the diagnosis to be multiple sclerosis; and
- b. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months;

2. Other causes of neurological damage such as SLE and HIV are excluded.

**12) BENIGN BRAIN TUMOR**

I. Benign brain tumor is defined as a life threatening, non-cancerous tumor in the brain, cranial nerves or meninges within the skull. The presence of the underlying tumor must be confirmed by imaging studies such as CT scan or MRI.

II. This brain tumor must result in at least one of the following and must be confirmed by the relevant medical specialist.

- i. Permanent Neurological deficit with persisting clinical symptoms for a continuous period of at least 90 consecutive days or
- ii. Undergone surgical resection or radiation therapy to treat the brain tumor.

III. The following conditions are excluded:

Cysts, Granulomas, malformations in the arteries or veins of the brain, hematomas, abscesses, pituitary tumors, tumors of skull bones and tumors of the spinal cord.

**13) AORTA GRAFT SURGERY**

The actual undergoing of major Surgery to repair or correct aneurysm, narrowing, obstruction or dissection of the Aorta through surgical opening of the chest or abdomen. For the purpose of this cover the definition of "Aorta" shall mean the thoracic and abdominal aorta but not its branches.

(a) The following conditions are excluded:

- (i) Surgery performed using only minimally invasive or intra-arterial techniques.
- (ii) Angioplasty and all other intra-arterial, catheter based techniques, "keyhole" or laser procedures.

(b) The diagnosis to be evidenced by any two of the following:

- (i) Computerized tomography (CT) scan
- (ii) Magnetic Resonance Imaging (MRI) scan
- (iii) Echocardiography (an ultrasound of the heart)
- (iv) Angiography (Injecting X ray dye)
- (v) Abdominal ultrasound

**14) THIRD DEGREE (OR MAJOR) BURNS**

There must be third-degree burns with scarring that cover at least 20% of the body's surface area. The diagnosis must confirm the total area involved using standardized, clinically accepted, body surface area charts covering 20% of the body surface area.

**15) PRIMARY (IDIOPATHIC) PULMONARY HYPERTENSION**

I. An unequivocal diagnosis of Primary (Idiopathic) Pulmonary Hypertension by a Cardiologist or specialist in respiratory medicine with evidence of right ventricular enlargement and the pulmonary artery pressure above 30 mm of Hg on Cardiac Catheterization. There must be permanent irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of cardiac impairment.

II. The NYHA Classification of Cardiac Impairment are as follows:

- i. Class III: Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms.
- ii. Class IV: Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest.

III. Pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, drugs and toxins, diseases of the left side of the heart, congenital heart disease and any secondary cause are specifically excluded.

**16) END STAGE LIVER FAILURE**

I. Permanent and irreversible failure of liver function that has resulted in all three of the following:

- i. Permanent jaundice; and
- ii. Ascites; and
- iii. Hepatic encephalopathy.

II. Liver failure secondary to drug or alcohol abuse is excluded.

**17) DEAFNESS**

Total and irreversible loss of hearing in both ears as a result of illness or accident. This diagnosis must be supported by pure tone audiogram test and certified by an Ear, Nose and Throat (ENT) specialist. Total means "the loss of hearing to the extent that the loss is greater than 90decibels across all frequencies of hearing" in both ears.

**18) LOSS OF SPEECH**

Total and irrecoverable loss of the ability to speak as a result of injury or disease to the vocal cords. The inability to speak must be established for a continuous period of 12 months. This diagnosis must be supported by medical evidence furnished by an Ear, Nose,

Throat (ENT) specialist.

II. All psychiatric related causes are excluded.

#### **Extension HC 7 - Maternity Benefit**

We will indemnify the Medical Expenses incurred up to the Maternity Benefit Sum Insured specified in the Policy Schedule for this Extension for the delivery of the Insured Person's child (including caesarian section) during Hospitalisation or the Medically Necessary and lawful medical termination of pregnancy during the Policy Period provided that:

- (a) We shall not be liable to make any payment under this Extension until the waiting period specified in the Policy Schedule for this Extension has expired;
- (b) The cover shall be available to the Insured between 18 to 45 years where the Insured should have been continuously covered for at least 36 months with this optional extension.
- (c) We shall not be liable to more than 2 deliveries or terminations across all Policy Periods with Us;
- (d) We will cover pre-natal and post-natal expenses up to the amount specified in the Policy Schedule for this Extension provided that We have accepted a Claim for delivery/termination under this Extension;
- (e) Payment under this Extension will not impact the opted base annual sum Insured or the Cumulative Bonus (if any);
- (f) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ floater).
- (g) The payment under this benefit is over and above the opted Base Annual Sum Insured.
- (h) We will not indemnify any Pre-Hospitalisation Medical Expenses or Post-Hospitalisation Medical Expenses under this Extension;
- (i) Ectopic pregnancy shall not be covered under this Extension, but any Claims will be considered under In-patient Treatment;

Exclusion 3.4 (o) of the Policy Wordings stands deleted to the extent of this Extension only.

#### **Extension HC 8 - New Born Baby Cover**

We will indemnify the Medical Expenses incurred on the Hospitalisation of the Insured Person's New Born Baby during the Policy Period up to the limits of the Base Annual Sum Insured (subject to availability of Base Annual Sum Insured). Subject to the terms and conditions of the Policy, We will cover the New Born Baby beyond 90 days on payment of requisite

Premium for the New Born Baby into the Policy by way of an endorsement or at the next Renewal, whichever is earlier.

- (a) In case of Individual policy, this payout will available on Individual basis and In case of floater the payout will be available on floater basis.
- (b) The payment under this benefit is within the opted Base Annual Sum Insured.
- (c) Any pre and post Hospitalisation expenses for the new born shall not be covered under this benefit.

#### **Extension HC 9 - Compassionate Visit**

We will indemnify the costs of a return (to and fro) economy class domestic air ticket for one of the Insured Person's Immediate Relative to travel from the place of the Immediate Relative's residence to the Hospital where the Insured Person is hospitalized, in case of the Insured Person's Hospitalisation extends beyond 5 consecutive days.

This benefit is payable, provided a claim is admitted under this policy. For the purpose of this Extension, the term "Immediate Relative" would mean the Insured Person's spouse, dependent children or dependent parents.

#### **Extension HC 10 - Restoration of Sum Insured**

We will provide a 100% restoration of the opted Base Annual Sum Insured once in a Policy Year if the opted Base Annual Sum Insured

and the Cumulative Bonus (if any) is insufficient as a result of previous Claims in that Policy Year, provided that:

- (a) The restored Base Annual Sum Insured will only be available for future Claims under the Policy and not in respect of any Claims for any Illness (including its complications) in respect of which a Claim has already been accepted in that Policy Year;
- (b) No Cumulative Bonus will apply on the restored Base Annual Sum Insured;
- (c) The restored Base Annual Sum Insured will apply to all Insured Persons on the same basis as the opted Base Annual Sum Insured;
- (d) Benefit under this extension is applicable only for basic covers but not for any optional extensions
- (e) Any restored Base Annual Sum Insured which is not utilized in a Policy Year shall not be carried forward to any subsequent Policy Year;
- (f) We shall not restore the Base Annual Sum Insured more than once in any Policy Year;
- (g) Restoration of Sum Insured will be in addition to opted Base Annual Sum Insured.
- (h) In case of Individual policy, payment under this cover shall be available on Individual basis and In case of floater the payment shall be will be available on floater basis.

#### **Extension HC 11 - Double Sum Insured for Hospitalisation due to Accident**

We will indemnify Medical Expenses incurred in respect of the Insured Person's Hospitalisation during the Policy Period in respect of an Injury sustained solely and directly due to an Accident which occurs during the Policy Period upto twice the opted Base Annual Sum Insured provided that:

- (a) In calculating the amount available to the Insured Person under this Extension, We shall deduct any amount previously paid from twice the opted Base Annual Sum Insured during the Policy Year;
- (b) The amount calculated under this Extension shall not be available for Medical Expenses incurred for treatment of any other Injury or Illness;
- (c) The amount calculated under this Extension shall not be available for payment of benefits under any provision other than the In-patient Treatment cover under the Policy;
- (d) This benefit is applicable on an individual basis irrespective of type of policy (Individual/ floater).
- (e) The payment under this benefit is over and above the opted Base Annual Sum Insured.
- (f) If this amount is un-utilised (in whole or in part) in any Policy Year, it shall not be carried forward to any subsequent Policy Year.

#### **Extension HC 12 - Cap on Room Rent**

If We accepted a Claim for In-patient Hospitalization under the Policy and if the Insured Person incurs Room Rent that is higher than the eligible Room Rent as specified in the Policy Schedule then We will be liable to pay only a rateable proportion of the Medical Expenses incurred in the proportion of the difference between "the Room Rent and the Associated Medical Expenses" of the eligible Room Rent and "the Room Rent and the Associated Medical Expenses" actually incurred, provided that Reasonable and Customary costs incurred on medicines/pharmacy, medical consumables, medical implants and diagnostic costs will be reimbursed based on the actual amounts incurred.

Proportionate deductions will not be applied in respect of the hospitals which do not follow differential billing or for those expenses in respect of which differential billing is not adopted based on the room category. Further, proportionate deductions will not be applied in respect of ICU Charges.

Under this optional extension the insured is entitled for a discount in base premium as entitled on opting the Cap on Room Rent.

## Annexure II: List of Day Care Surgeries

<b>Sr. No</b>	<b>Operations on the eyes</b>	41	Partial glossectomy
1	Incision of tear glands	42	Glossectomy
2	Other operations on the tear ducts	43	Reconstruction of the tongue
3	Incision of diseased eyelids	44	Other operations on the tongue
4	Excision and destruction of diseased tissue of the eyelid	<b>Other operations on the mouth &amp; face</b>	
5	Operations on the canthus and epicanthus	45	External incision and drainage in the region of the mouth, jaw and face
6	Corrective surgery for entropion and ectropion	46	Incision of the hard and soft palate
7	Corrective surgery for blepharoptosis	47	Excision and destruction of diseased hard and soft palate
8	Removal of a foreign body from the conjunctiva	48	Incision, excision and destruction in the mouth
9	Removal of a foreign body from the cornea	49	Plastic surgery to the floor of the mouth
10	Incision of the cornea	50	Palatoplasty
11	Operations for pterygium	51	Other operations in the mouth
12	Other operations on the cornea	<b>Operations on the tonsils &amp; adenoids</b>	
13	Removal of a foreign body from the lens of the eye	52	Transoral incision and drainage of a pharyngeal abscess
14	Removal of a foreign body from the posterior chamber of the eye	53	Tonsillectomy without adenoidectomy
15	Removal of a foreign body from the orbit and eyeball	54	Tonsillectomy with adenoidectomy
16	Operation of cataract	55	Excision and destruction of a lingual tonsil
<b>Operations on the nose &amp; the nasal sinuses</b>		56	Other operations on the tonsils and adenoids
17	Excision and destruction of diseased tissue of the nose	<b>Operations on the salivary glands &amp; salivary ducts</b>	
18	Operations on the turbinates (nasal concha)	57	Incision and lancing of a salivary gland and a salivary duct
19	Other operations on the nose	58	Excision of diseased tissue of a salivary gland and a salivary duct
20	Nasal sinus aspiration	59	Resection of a salivary gland
21	Foreign body removal from nose	60	Reconstruction of a salivary gland and a salivary duct
<b>Microsurgical operations on the middle ear</b>		61	Other operations on the salivary glands and salivary ducts
22	Stapedotomy	<b>Operations on the breast</b>	
23	Stapedectomy	62	Incision of the breast
24	Revision of a stapedectomy	63	Operations on the nipple
25	Other operations on the auditory ossicles	<b>Operations on the skin &amp; subcutaneous tissues</b>	
26	Myringoplasty (Type -I Tympanoplasty)	64	Incision of a pilonidal sinus
27	Tympanoplasty (closure of an eardrum perforation/ reconstruction of the auditory ossicles)	65	Other incisions of the skin and subcutaneous tissues
28	Revision of a tympanoplasty	66	Surgical wound toilet (wound debridement) and removal of diseased tissue of the skin and subcutaneous tissues
29	Other microsurgical operations on the middle ear	67	Local excision of diseased tissue of the skin and subcutaneous tissues
<b>Other operations on the middle &amp; internal ear</b>		68	Other excisions of the skin and subcutaneous tissues
30	Myringotomy	69	Simple restoration of surface continuity of the skin and subcutaneous tissues
31	Removal of a tympanic drain	70	Free skin transplantation, donor site
32	Incision of the mastoid process and middle ear	71	Free skin transplantation, recipient site
33	Mastoidectomy	72	Revision of skin plasty
34	Reconstruction of the middle ear	73	Other restoration and reconstruction of the skin and subcutaneous tissues.
35	Other excisions of the middle and inner ear	74	Chemosurgery to the skin.
36	Fenestration of the inner ear	75	Destruction of diseased tissue in the skin and subcutaneous tissues
37	Revision of a fenestration of the inner ear	<b>Operations on the digestive tract</b>	
38	Incision (opening) and destruction (elimination) of the inner ear	76	Incision and excision of tissue in the perianal region
39	Other operations on the middle and inner ear	77	Surgical treatment of anal fistulas
<b>Operations on the tongue</b>		78	Surgical treatment of haemorrhoids
40	Incision, excision and destruction of diseased tissue of the tongue		

79	Division of the anal sphincter (sphincterotomy)
80	Other operations on the anus
81	Ultrasound guided aspirations
82	Sclerotherapy etc.

### Operations of bones and joints

83	Surgery for ligament tear
84	Surgery for meniscus tear
85	Surgery for hemoarthrosis/ pyoarthrosis
86	Removal of fracture pins/ nails
87	Removal of metal wire
88	Closed reduction on fracture, luxation
89	Reduction of dislocation under GA
90	Epiphyseolysis with osteosynthesis
91	Trauma surgery and orthopaedics
92	Incision on bone, septic and aseptic
93	Closed reduction on fracture, luxation or epiphyseolysis with osteosynthesis
94	Suture and other operations on tendons and tendon sheath

### Operations on the female sexual organs

96	Incision of the ovary
97	Insufflation of the fallopian tubes
98	Other operations on the Fallopian tube
99	Dilatation of the cervical canal
100	Conisation of the uterine cervix
101	Other operations on the uterine cervix
102	Incision of the uterus (hysterotomy)
103	Therapeutic curettage
104	Culdotomy
105	Incision of the vagina
106	Local excision and destruction of diseased tissue of the vagina and the pouch of Douglas
107	Incision of the vulva
108	Operations on Bartholin's glands (cyst)

### Operations on the prostate & seminal vesicles

109	Incision of the prostate
110	Transurethral excision and destruction of prostate tissue
111	Transurethral and percutaneous destruction of prostate tissue
112	Open surgical excision and destruction of prostate tissue
113	Radical prostatovesiculectomy
114	Other excision and destruction of prostate tissue
115	Operations on the seminal vesicles
116	Incision and excision of periprostatic tissue
117	Other operations on the prostate

### Operations on the scrotum & tunica vaginalis testis

118	Incision of the scrotum and tunica vaginalis testis
119	Operation on a testicular hydrocele
120	Excision and destruction of diseased scrotal tissue
121	Plastic reconstruction of the scrotum and tunica vaginalis testis
122	Other operations on the scrotum and tunica vaginalis testis

### Operations on the testes

123	Incision of the testes
124	Excision and destruction of diseased tissue of the testes
125	Unilateral orchidectomy
126	Bilateral orchidectomy
127	Orchidopexy
128	Abdominal exploration in cryptorchidism
129	Surgical repositioning of an abdominal testis
130	Reconstruction of the testis
131	Implantation, exchange and removal of a testicular prosthesis
132	Other operations on the testis

### Operations on the spermatic cord, epididymis and ductus deferens

133	Surgical treatment of a varicocele and a hydrocele of the spermatic cord
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### Operations on the spermatic cord, epididymis and ductus deferens

134	Excision in the area of the epididymis
135	Epididymectomy
136	Reconstruction of the spermatic cord
137	Reconstruction of the ductus deferens and epididymis
138	Other operations on the spermatic cord, epididymis and ductus deferens

### Operations on the penis

139	Operations on the foreskin
140	Local excision and destruction of diseased tissue of the penis
141	Amputation of the penis
142	Plastic reconstruction of the penis
143	Other operations on the penis

### Operations on the urinary system

144	Cystoscopic removal of stones
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### Other Operations

145	Lithotripsy
146	Coronary angiography
147	Haemodialysis
148	Radiotherapy for Cancer
149	Cancer Chemotherapy
150	Endoscopic polypectomy



## Annexure III - List I: List of non - medical expenses

Sr. No.	Items	Suggestions
1	Baby Food	Not Payable
2	Baby Utilities Charges	Not Payable
3	Beauty Services	Not Payable
4	Belts/ Braces	Payable for cases who have undergone surgery of Thoracic or Lumbar Spine.
5	Buds	Not Payable
6	Cold Pack/Hot Pack	Not Payable
7	Carry Bags	Not Payable
8	Email / Internet Charges	Not Payable
9	Food Charges (other than Patient's Diet Provided by Hospital)	Not Payable
10	Leggings	Payable in case of Bariatric and Varicose Vein Surgery
11	Laundry Charges	Not Payable
12	Mineral Water	Not Payable
13	Sanitary Pad	Not Payable
14	Telephone Charges	Not Payable
15	Guest Services	Not Payable
16	Crepe Bandage	Not Payable
17	Diaper Of Any Type	Not Payable
18	Eyelet Collar	Not Payable
19	Slings	Not Payable
20	Blood Grouping and Cross Matching of Donors Samples	Not Payable
21	Service Charges Where Nursing Charge Also Charged	Post Hospitalization Nursing Charges Not Payable
22	Television Charges	Not Payable
23	Surcharges	Not Payable
24	Attendant Charges	Not Payable
25	Extra Diet Of Patient (Other Than That Which Forms Part of Bed Charge)	Not Payable
26	Birth Certificate	Not Payable
27	Certificate Charges	Not Payable
28	Courier Charges	Not Payable
29	Conveyance Charges	Not Payable
30	Medical Certificate	Not Payable
31	Medical Records	Not Payable
32	Photocopies Charges	Not Payable
33	Mortuary Charges	Payable Up to 24 Hrs, Shifting Charges Not Payable
34	Walking Aids Charges	Not Payable
35	Oxygen Cylinder (For Usage Outside The Hospital)	Not Payable
36	Spacer	Not Payable
37	Spirometre	Not Payable
38	Nebulizer Kit	Not Payable
39	Steam Inhaler	Not Payable
40	Armsling	Not Payable
41	Thermometer	Not Payable
42	Cervical Collar	Not Payable
43	Splint	Not Payable

44	Diabetic Foot Wear	Not Payable
45	Knee Braces (Long/ Short/ Hinged)	Not Payable
46	Knee Immobilizer/Shoulder Immobilizer	Not Payable
47	Lumbo Sacral Belt	Payable for cases who have undergone Surgery of Lumbar Spine
48	Nimbus Bed Or Water Or Air Bed Charges	Not Payable
49	Ambulance Collar	Not Payable
50	Ambulance Equipment	Not Payable
51	Abdominal Binder	Payable in case of post-surgery patients of Major Abdominal Surgery Including TAH, LSCS, Incisional Hernia Repair, Exploratory Laparotomy for Intestinal Obstruction, Liver Transplant Etc
52	Private Nurses Charges- Special Nursing Charges	Not Payable
53	Sugar Free Tablets	Not Payable
54	Creams Powders Lotions (Toiletries Are Not Payable, Only Prescribed Medical Pharmaceuticals Payable)	Not Payable
55	ECG Electrodes	Not Payable
56	Gloves	Sterilized Gloves Payable / Unsterilized Gloves not payable
57	Nebulisation Kit	Not Payable
58	Any Kit With No Details Mentioned [Delivery Kit, Orthokit, Recovery Kit, Etc]	Not Payable
59	Kidney Tray	Not Payable
60	Mask	Not Payable
61	Ounce Glass	Not Payable
62	Oxygen Mask	Not Payable
63	Pelvic Traction Belt	Payable in case of PIVD requiring traction
64	Pan Can	Not Payable
65	Trolley Cover	Not Payable
66	Urometer, Urine Jug	Not Payable
67	Ambulance	Payable - Ambulance from home to Hospital or inter-hospital shifts is Payable/ RTA - As Specific Requirement for critical injury is Payable
68	Vasofix Safety	Not Payable

### List II – Items that are to be subsumed into Room Charges

Sr. No	Item		
1	Baby Charges (Unless Specified/Indicated)	13	Tooth Brush
2	Hand Wash	14	Bed Pan
3	Shoe Cover	15	Face Mask
4	Caps	16	Flexi Mask
5	Cradle Charges	17	Hand Holder
6	Comb	18	Sputum Cup
7	Eau-De-Cologne / Room Freshners	19	Disinfectant Lotions
8	Foot Cover	20	Luxury Tax
9	Gown	21	Hvac
10	Slippers	22	House Keeping Charges
11	Tissue Paper	23	Air Conditioner Charges
12	Tooth Paste	24	Im Iv Injection Charges

25	Clean Sheet	32	Entrance Pass / Visitors Pass Charges
26	Blanket/Warmer Blanket	33	Expenses Related To Prescription On Discharge
27	Admission Kit	34	File Opening Charges
28	Diabetic Chart Charges	35	Incidental Expenses / Misc. Charges (Not Explained)
29	Documentation Charges / Administrative Expenses	36	Patient Identification Band / Name Tag
30	Discharge Procedure Charges	37	Pulseoxymeter Charges
31	Daily Chart Charges		

### List III – Items that are to be subsumed into Procedure Charges

Sr No.	Item		
1	Hair Removal Cream	13	Surgical Drill
2	Disposables Razors Charges (For Site Preparations)	14	Eye Kit
3	Eye Pad	15	Eye Drape
4	Eye Sheild	16	X-Ray Film
5	Camera Cover	17	Boyles Apparatus Charges
6	Dvd, Cd Charges	18	Cotton
7	Gause Soft	19	Cotton Bandage
8	Gauze	20	Surgical Tape
9	Ward And Theatre Booking Charges	21	Apron
10	Arthroscopy And Endoscopy Instruments	22	Torniquet
11	Microscope Cover	23	Orthobundle, Gynaec Bundle
12	Surgical Blades, Harmonicsscalpel,Shaver		

### List IV – Items that are to be subsumed into costs of treatment

Sr. No.	Item		
1	Admission/Registration Charges	10	Hiv Kit
2	Hospitalisation For Evaluation/ Diagnostic Purpose	11	Antiseptic Mouthwash
3	Urine Container	12	Lozenges
4	Blood Reservations Charges And Ante Natal Booking Charges	13	Mouth Paint
5	Bipap Machine	14	Vaccination Charges
6	Cpap/ Capd Equipments	15	Alcohol Swabes
7	Infusion Pump– Cost	16	Scrub Solution/ Sterillium
8	Hydrogen Peroxide\Spirit\ Disinfectants Etc	17	Glucometer& Strips
9	Nutrition Planning Charges - Dietician Charges- Diet Charges	18	Urine Bag